Towards DSM-V and ICD-11

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What’s wrong with DSM-4 and ICD-10?

- Whole classification needlessly complex - too many chapters, and numbers of disorders increases sharply with each new edition
- Closely related disorders are assigned to different chapters, and no more hierarchies: thus the bogus idea of “co-morbidity”
- Excessive use made of “Not Otherwise Classified” (NOC)
- Almost no attempt at validity: main criterion is symptom similarity
Karl Jaspers asserted:

"...Classification... has only a provisional value. It is a fiction which will discharge its function if it proves to be the most apt for the time."

"...eine solche Einteilung hat daher nur einen stets vorläufigen Ordnungswert. Sie ist eine Fiktion, die ihre Aufgabe erfüllt, wenn sie die zur Zeit relativ richtigste ist"

Allgemeine Psychopathologie, 5 Aufl., Springer, 1927
Successive versions of the DSM

- DSM-II
- DSM-III
- DSM-III-R
- DSM-IV

Hierarchical, Chinese menus

Birth of comorbidity industry

Disorders defined by impairment/distress
Successive versions of the ICD

←ICD-7 1955
←ICD-8 1975
←ICD-9 1967
←ICD-10 1994
Successive ICD Revisions
Where have they got up to?

ICD-11: Regular meetings for 3 years, definite increase of activity in past 6 months. Main Group re-formed 2010, & Special Groups (Primary Care, Children, Substance abuse &c) set up and meeting; few decisions yet

DSM-5: Meetings for 3.5 years, working to a tight timetable: modification posted on internet 10.02.10; field trials in progress; further revisions may 2011; all stages of work completed by end 2012.
Where have they got up to?

**ICD-11**: A huge task – to revise entire ICD for all diseases, not just mental disorders. All parts of the world represented. Use of internet and IT technology emphasised. US Chairman to Main Committee. Clinical descriptions, not research criteria?

**DSM-5**: For first time, almost 50% of advisers are not from the USA. Firm commitment to Chinese menus. Modifications mainly based on research data. Many special groups meet in pairs to communicate across disorders.
Where have they got up to?

ICD-11: Sympathetic hearing to proposal to revise entire basis of classification, but no decision. Co-morbidity acknowledged as major problem. Hope to avoid minor discrepancies between DSM & ICD, but ICD is independent!

DSM-5: Co-morbidity and “NOS diagnoses” still seen as major problems. Structure of groups cause some turf battles, but constructive discussion prevails. Will DSM-V use ICD-11 codes, or continue with ICD-9 codes? DSM also independent!
The ICD-11 Primary Care Group

Equal numbers of psychiatrists and GPs, each WHO Region represented, developing as well as developed countries, equal numbers of males & female members.

Two GP members are senior members of WONCA

Very enthusiastic. Against needless co-morbidity. Against special version for developing countries.

Should the dog wag the tail, or the tail wag the dog?
The ICD 10 - PHC, 1992

✓ only 25 disorders, all common in PHC

✓ clinical descriptions not research Dx

✓ how each disorder commonly presents, how to manage each disorder

✓ psychological as well as medical interventions

✓ each country free to make minor adaptations to suit their clinicians; uncommon disorders in a country can be omitted
13 Common mental disorders

1 Depression (F 32)
2 Phobic disorders (F 40)
3 Panic disorders (F 41.0)
4 Generalised anxiety (F 41.1)
5 Mixed anxiety depression (F 41.2)
6 Adjustment disorder (F 43)
7 Dissociative (conversion) disorder (F 44)
8 Unexplained somatic complaints (F 45)
9 Neurasthenia (F 48.0)
10 Eating disorders (F 50)
11 Sleep problems (F 51)
12 Sexual disorders (F 52)
13 Bereavement (Z 63)
12 other disorders

**Addictive Disorders**
14 Alcohol use disorder (F 10)
15 Drug use disorder (F 11)
16 Tobacco use disorder (F 17.1)

**Organic Disorders**
17 Dementia (F 00)
18 Delirium (F 05)

**Psychotic Disorders**
19 Chronic psychotic disorders (F 20)
20 Acute psychotic disorders (F 23)
21 Bipolar disorders (F 3)

**Disorders of Childhood**
22 Mental retardation (F 70)
23 Hyperkinetic (attention deficit) disorder (F 90)
24 Conduct disorder (F 91)
25 Enuresis (F 98.0)
The task before us

✓ Consider the need to modify the list of disorders by adding, omitting or modifying the 25 disorders.
✓ Propose Field trials of the new classification
✓ Ensure that there is equivalence between our disorders and those in the parent classification
✓ Prepare translations into the WHO official languages
✓ Consider ways of distributing the classification electronically, at no cost.
WHO published ICD10-PHC
Hogrefe Huber 1996

✓ 25 disorders unchanged
✓ many modifications introduced after field trials
✓ sexual disorders divided (male and female)
✓ brief version released for health workers (6 conditions only)
The “SAD” Triad
Lowe et al, Gen Hosp Psychiatry 2008

PHQ scores $\geq 15$

Pure forms of:
- Depression = 26%
- Anxiety = 43%
- Somatization = 46%

15 primary care clinics (n = 2091 patients)
Will there be Anxious depression?

GP’s are pretty unanimous that they need it.

There could be subdivisions within it: “predominantly anxious” and “predominantly depressed”.

(There might be a “somatic symptoms specifier” as well)

WHO think that the primary care classification should drive the main ICD.
The DSM proposals

✓ all these are available on the APA Website: what follow is already in the public domain

✓ Discussion is proceeding about a simplified chapter structure between the ICD and the DSM

✓ Disorders common in primary care are: depressive, anxious & somatic manifestations of distress, as well as substance use disorders
"Somatoform Disorders, &c"

Separate Dx’s to be run together:

- Somatisation disorder
- Somatoform disorder
- Hypochondriasis
- Pain disorder

All to be known as:

**Complex Somatic Symptom Disorder**
Complex Somatic Symptom Disorder

Defined as a chronic disorder >6/12,

A. Somatic symptoms:
One or more somatic symptoms are distressing

B. Overwhelming concern or preoccupation with symptoms and illness:
At least three of the following are required to meet this criterion:

(1) High level of health-related anxiety.
(2) A tendency to fear the worst about one's health or bodily symptoms (catastrophizing).
(3) Belief in the medical seriousness of one's symptoms despite evidence to the contrary.
(4) Health concerns and/or symptoms assume a central role in one's life (ruminative preoccupation).
Complex Somatic Symptom Disorder

3 main sub-divisions:

i. xxx.01 Multiplicity of somatic complaints
ii. xxx.02 High health anxiety (was hypochondrias)
iii. xxx.03 Pain disorder

(As well as CSSD NOS:
  • Pseudocyesis
  • hypochondriacal symptoms <6/12
  • unexplained physical complaints (e.g., fatigue or body weakness) <6/12)
Conversion Disorder

Criteria A, B, and C must all be fulfilled to make the diagnosis:
A. One or more symptoms are present that affect voluntary motor or sensory function.
B. The symptom, after appropriate medical assessment, is found not to be due to a general medical condition, the direct effects of a substance, or a culturally sanctioned behavior or experience.
C. The symptom causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation. removing the requirement that the clinician actively establish that the patient is not feigning, and that there are associated psychological factors obtaining positive evidence of the diagnosis from appropriate neurological assessment and testing.
Dysthymic Disorder

Re-name: Chronic depressive disorder

A. Most of day, most of days, 6/12+

B. 2+ of 6 features
   • Poor appetite or overeating
   • Insomnia or hypersomnia
   • Low energy or fatigue
   • Low self-esteem
   • Poor concentration or diff. making decisions
   • Feelings of hopelessness….

H. Ss cause social, occupational dysfunction
Generalized Anxiety Disorder: DSM-4
(Includes Overanxious Disorder of Childhood)

A. Excessive anxiety and worry more days than not for 6/12+,
B. The person finds it difficult to control the worry.
C. 3+ (1+ in children) of
   1. Restlessness, on edge
   2. Easily fatigued
   3. Difficulty concentrating, mind → blank
   4. Irritability
   5. Muscle tension
   6. Sleep disturbance
Generalized Anxiety Disorder

A. Excessive anxiety and worry about 2+ domains of activities or events
B. The excessive anxiety and worry more days than not, 3/12+
C. one or both of the following symptoms:
   a. Restlessness, feeling keyed up, or on edge
   b. Muscle tension
D. one or more of the following behaviors:
   a. avoidance of situations with negative outcomes
   b. time and effort preparing for possible negative outcomes
   c. procrastination in behavior or decision-making
   d. Repeatedly seeking reassurance
A. Five (or more) of the following criteria have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day (in children and adolescents, can be irritable mood).
2. Loss of interest or pleasure almost all activities
3. Significant weight loss/gain; appetite loss/gain (in children, consider failure to gain weight)
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or inappropriate guilt
8. ↓ ability to think or concentrate, or indecisiveness
9. Recurrent thoughts of death
Mixed Anxiety Depression

3 or 4 symptoms of depression plus anxious distress

Anxious Distress- defined as 3 or more anxious symptoms.
0. Not anxious
1. Mildly anxious
2. Moderate Anxiety - 2 symptoms
3. Severely Anxious 3-5 symptoms
4. Severely anxious with motor agitation

Anxious Symptoms:
- describes (irrational) worries
- feels uneasy
- feels nervous
- motor tension
- feels something awful may happen
Panic Disorder
(no longer c/cx agoraphobia)

A. Recurrent unexpected panic attacks

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
   1. Persistent concern or worry about additional panic attacks
   2. Significant maladaptive change in behavior related to the attacks

C. Not caused by drug of abuse, a medication) or a general medical condition
Alcohol Use Disorder
(no longer abuse/dependence)

A pattern of alcohol use with impairment/distress
with 2+ (or more) of the following, (within 1 year)

- failure to fulfil major role obligations at work, school, or home
- use when physically hazardous
- continued use despite persistent social/interpersonal probs.
- tolerance (↑ dose / more needed for same effect)
- withdrawal symptoms
- alcohol taken in larger amounts than was intended
- persistent desire or unsuccessful efforts to cut down
- much time spent to obtain the substance or recover from it
- important activities are given up or reduced
- alcohol continued despite knowledge of harmful effects
- craving or a strong desire or urge to use alcohol
What about “NOS” Dx's?
(re-name, Not elsewhere classified NEC)!
Depression NEC
(was Depression NOS)

xxx.1 Depressive CNEC with insufficient information to make a specific diagnosis. Patient is unable or unwilling to provide information. Clinician does not have the time or training needed.

xxx.2 Subsyndromal Depressive CNEC
Prodromal / subsyndromal

xxx.3 Other Depressive CNEC
Recurrent Brief Depressive Disorder
Premenstrual Dysphoric Disorder
Schizophrenia

Two or more of (including 1+ of 1, 2 or 3)
1. Delusions
2. Hallucinations
3. Disorganized speech
4. Grossly abnormal psychomotor behavior, such as catatonia
5. Negative symptoms, i.e., restricted affect or avolition/asociality

(With Social/occupational dysfunction & >6/12)

But “Kraepelinian types” abandoned
Dimensions of psychosis

1. Hallucinations
2. Delusions
3. Disorganization
4. Abnormal Psychomotor Behavior
5. Restricted Emotional Expression
6. Avolition
7. Impaired Cognition
8. Depression
9. Mania
Some of the new boys on the block......
Premenstrual Dysphoric Disorder

A. Most menstrual cycles during the past year, 5+ of the following
   • occurred during final week before onset of menses
   • started to improve within a few days after the onset of menses
   • were minimal or absent in the week post-menses,

(1) depressed mood, hopelessness,
(2) anxiety, feelings of being keyed up
(3) affective lability
(4) irritability or anger or increased interpersonal conflicts
(5) decreased interest in usual activities
(6) poor concentration
(7) lethargy, easy fatigability
(8) marked change in appetite, or specific food cravings
(9) hypersomnia or insomnia
(10) sense of being overwhelmed or out of control
(11) other physical symptoms such as breast tenderness

B. Clinically significant distress
Binge Eating Disorder

A. Recurrent episodes of binge eating with both of the following:
   1. eating within any 2-hour period an amount of food that is definitely larger than most people would eat
   2. a sense of lack of control over eating during the episode
B. The binge-eating episodes are associated with three (or more) of the following:
   1. eating much more rapidly than normal
   2. eating until feeling uncomfortably full
   3. eating large amounts of food when not feeling physically hungry
   4. eating alone because of being embarrassed
   5. feeling disgusted, depressed, or very guilty after overeating

C. Marked distress regarding binge eating/ >1/52 for 3/12/ No purging
What about Dimensions?

A rating of **anxiety** on a 5-point scale will be made in all cases of mood disorders.

A rating of **suicidal intentions** on a 5-point scale will be made in all cases of mood disorders.

Within schizophrenia, modest experiments will be made with a number of dimensions.
What about Co-morbidity?

It isn’t clear that there is much of a will to do much about it
For DSM-V and ICD-11 everything left to play for

Both are considering the meta-structure of the classification

Both have improved the representation of experts advising them

Draft changes of both will be field tested before adoption